ATTACHMENT C PART 6

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McLean	Siggers, Kevin	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor	Unit CB	3/24/05 0730
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Compound		3/24/05 0745

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

I INMATE SIGGERS fell on the ICE while WALKING to WORK. WAS WALKING TO FAST, AND FELL ON KNEE.

Kevin L Siggers Sr.
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

(1) knee - (+) tenderness over patellar tendon area, edema, ecchymosis, full ROM at stable

X-Rays Taken _____ *Not Indicated* X
X-Ray Results

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(1) Contusion, (2) knee

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

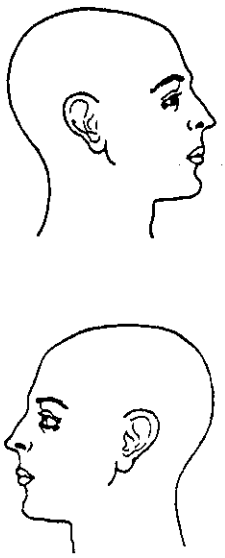
(1) Elastic knee support given
(2) Motrin 800 mg TID Prn #30 (c food)
(3) Pt Ed - rest, ice, and use he understands
(4) RTC if ↑ better

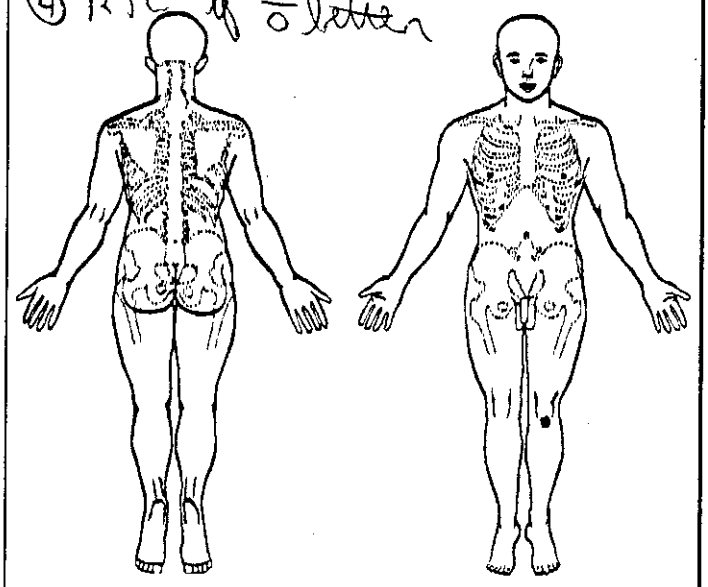
13. This Injury Required:

- ☐ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

see above

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician





Dennis Olson PA
Signature of Physician or Physician Assistant

Dennis Olson, MD
Physician

Medical Supervisor
Duty Supervisor (*Work related only*)
Correctional Supervisor

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BP-362(60)
FEBRUARY 1986

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Siggers, Kevin	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
UNICOR	CA	5/14/04 1910
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Rec Baseball Field		5/14/04 1950

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

ON TODAYS DATE, while making play AT HOMEBASE, collided with another INMATE. Hurt ANKLE & LEG.

Mr. Kevin Siggers
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken X 2 *Not Indicated* ____

X-Ray Results

+ contusion (L) Tib/Fib AREA; Pain 8/10, + Swelling w/ firmness; + pulses w/ sensation; - deformity or problems w/ mobility; Inmate state's he feel tingling after on; - trauma Noted to ankle

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

Bruised (L) Tib/Fib

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Educated inmate on icing, crutches; and NO Rec for two weeks; idle for NO WORK on 5/15/04; Instructed inmate to elevated when icing; Follow-up w/ PA @ Emerg Sick CALL on 5/17/04; Inmate agrees and understands plan.

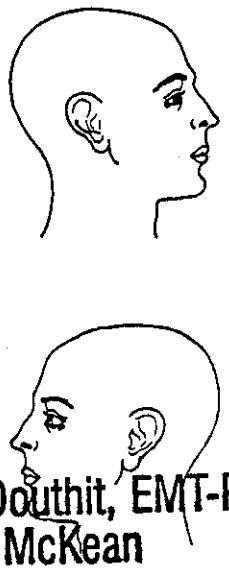
13. This Injury Required:

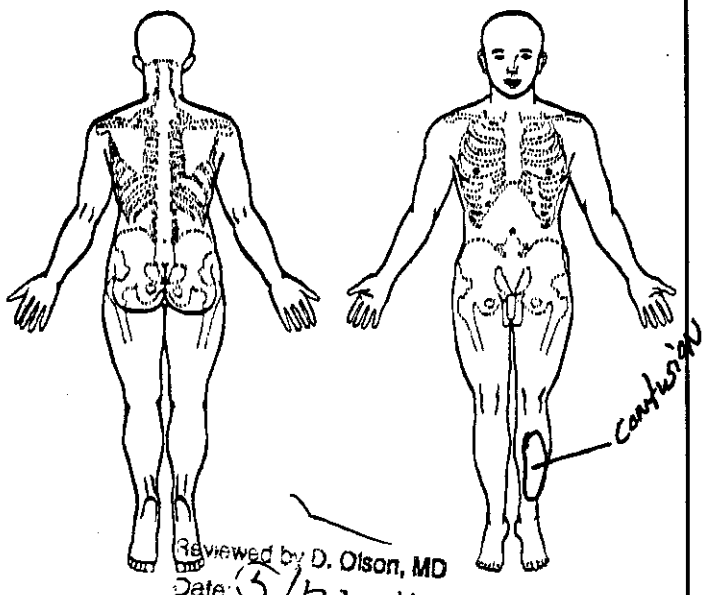
- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

  _____

  _____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician





B. Douthit EMT-P
Signature of Physician or Physician Assistant

B. Douthit, EMT-P
FCI McKean

Reviewed by D. Olson, MD
Date: 5/17/04

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Medical File
Safety
Supervisor (*Work related only*)
Correctional Supervisor

S. DEPARTMENT OF JUSTICE
deral Bureau of Prisons

INMATE INJURY SESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
PCI McKean	Suggs, Kevin	57627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
unemp	CA	11-18-03 @ 11[illegible]
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☑ No	**8. Date and Time Reported for Treatment**
Entrance door to food service		11/18/03 @ 1115

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

" A guy asked to speak to me. The next thing I know I'm waking up. I don't know if I was hit or something or pushed. States LOC x 30-60 sec."

Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

Cephalic ↓ c abrasion, 3cm x 2 on back of head. Laceration (L) nose - internal + external - Septum unstable. gauge mark (R) nose. 1/4" laceration c edema above (L) eye. A+O x 3. PERRLA. DTM WNL incontinent of stool.

X-Rays Taken _____ *Not Indicated* _____

X-Ray Results

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

abrasions + lacerations of face and head. r/o nasal septal fracture; LOC x 30-60 sec

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Wounds cleansed c H2O2 NS. Bacitracin applied to scalp, nose (R side) and over (L) eye. Schedule x ray of Septum. Steri strips x 3 applied to (L) nasal laceration. Motrin, 800 mg 1 tab PO q 8° c food #30 ck. Bacitracin #1, apply to AA's bid. PT ed, re: wound care RTC prn. Pt understands & agrees w/ Plan

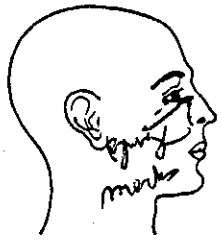
13. This Injury Required:

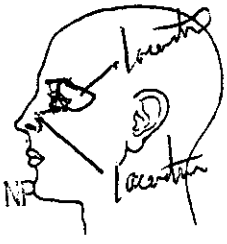
- ☐ a. No Medical Attention
- ☑ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

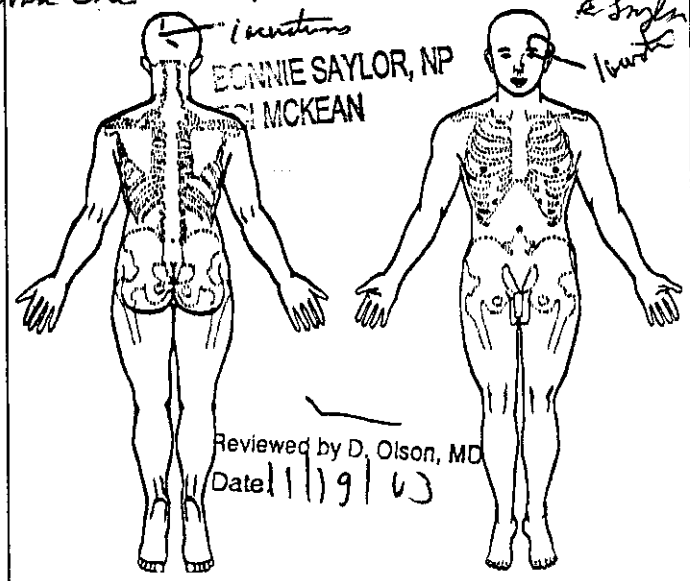
_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician







BONNIE SAYLOR, NP
MCKEAN

Reviewed by D. Olson, MD
Date: 11/19/03

Bonnie Saylor, NP
BONNIE SAYLOR, NP
PCI MCKEAN
ture of Physician or Physician Assistant

Or
Can
Pink ical File
Golde
USP LVI isor (*Work related only*)
nal Supervisor

***Self Carboned Form** – If ballpoint pen is used,* **PRESS HARD**

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJU[illegible]SMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Siggers, Kevin	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor	CA	2/14/01 1315
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☑ Yes ☐ No	**8. Date and Time Reported for Treatment**
In Unicor - Cold press machine		2/14/01 2025

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

I walked right into the end of the cold press machine & cut my (L) leg

Kevin Siggers
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

Superficial laceration on Shin of (L) leg. Minimal bleeding noted. Sl surrounding edema noted

X-Rays Taken ____ *Not Indicated* ✓
X-Ray Results

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

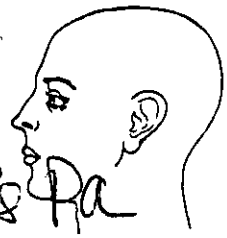
Superficial laceration (L) leg

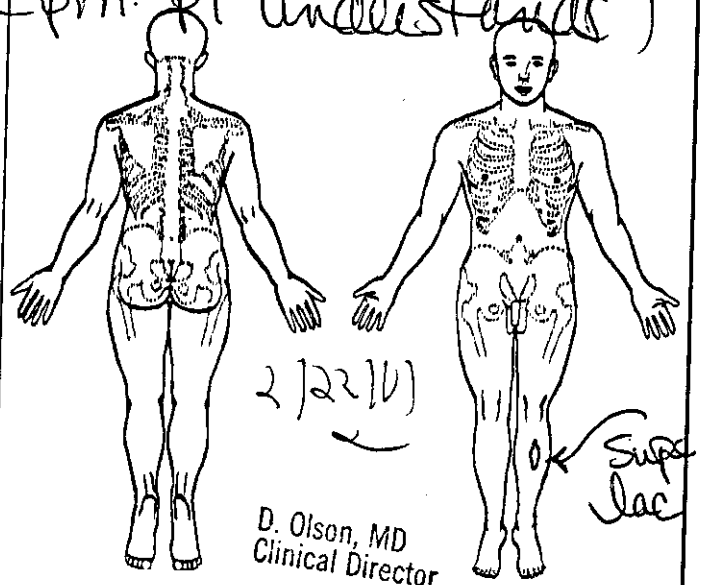
12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Wound cleansed c betadine + h2o2. Butterfly bandaid x 1 applied c Bandaid. Tylenol 325 mg #6 Given to pt. 1 tab Q6h prn. Keep area clean, dry. Band-aid prn. RTC prn. Pt understands

13. This Injury Required:

- ☐ a. No Medical Attention
- ☑ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)





- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Gracia Fairbanks PA
Signature of Physician or Physician Assistant

D. Olson, MD
Clinical Director

Gracia Fairbanks, MLP

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Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

JSP LVN

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BP–362(60)
FEBRUARY 1988

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJU SSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Siggers Kevin	51627060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor	CA	12/3/00 2020
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Recreation hobbycraft.		12/3/00 2220

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

I was horseplaying. I dont have any injuries on me.

x Kevin L. Siggers
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

Alert, well oriented

X-Rays Taken _____ *Not Indicated* ✓
X-Ray Results

Nothing found

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

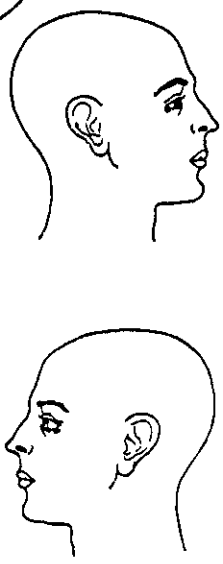
Nothing found.

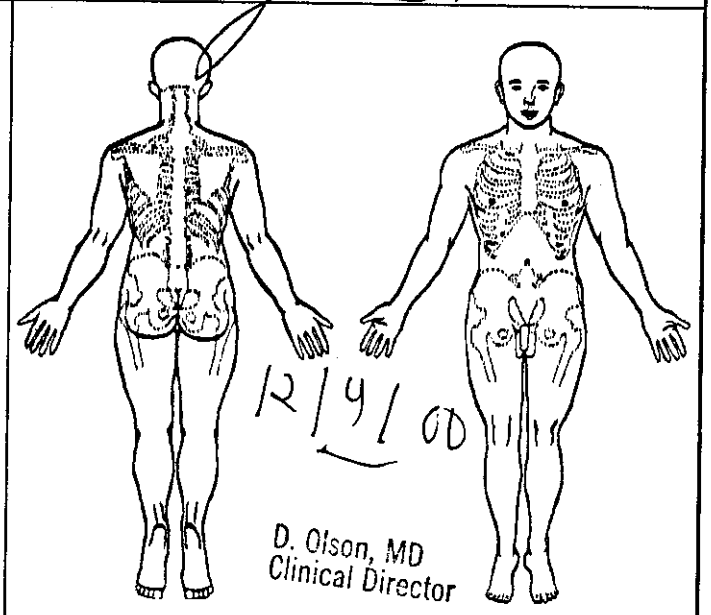
12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

1) nothing given
2) follow up sick call as needed.
3) Return to duty OK.

13. This Injury Required:

☒ a. No Medical Attention
☐ b. Minor First Aid
☐ c. Hospitalization
☐ d. Other (*explain*)
_____
_____
☐ e. Medically Unassigned
☐ f. Civilian First Aid Only
☐ g. Civilian Referred to Community Physician





12/4/00

D. Olson, MD
Clinical Director

Signature of Physician or Physician Assistant
P. Gomez, MD

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Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

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BP–362(60)
FEBRUARY 1986

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution McKean	2. Name of Injured Siggers Kevin	3. Register Number 51627-060
4. Injured's Duty Assignment Unicor	5. Housing Assignment CA	6. Date and Time of Injury 8/13/00 1745
7. Where Did Injury Happen (*Be specific as to location*) Softball field playing football — *Work Related?* ☐ Yes ☒ No		8. Date and Time Reported for Treatment 8/15/00 0816

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

When playing football I got sprain muscle in my R groin area, pain, tenderness.

X

Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken ____ *Not Indicated* X

X-Ray Results at this time.

Alert W/O RLQ

Sprain/strain groin muscle, no swelling no echymosis, subjective pain tenderness to palpation Allergic to motrin

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(R) side groin pull muscle.

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

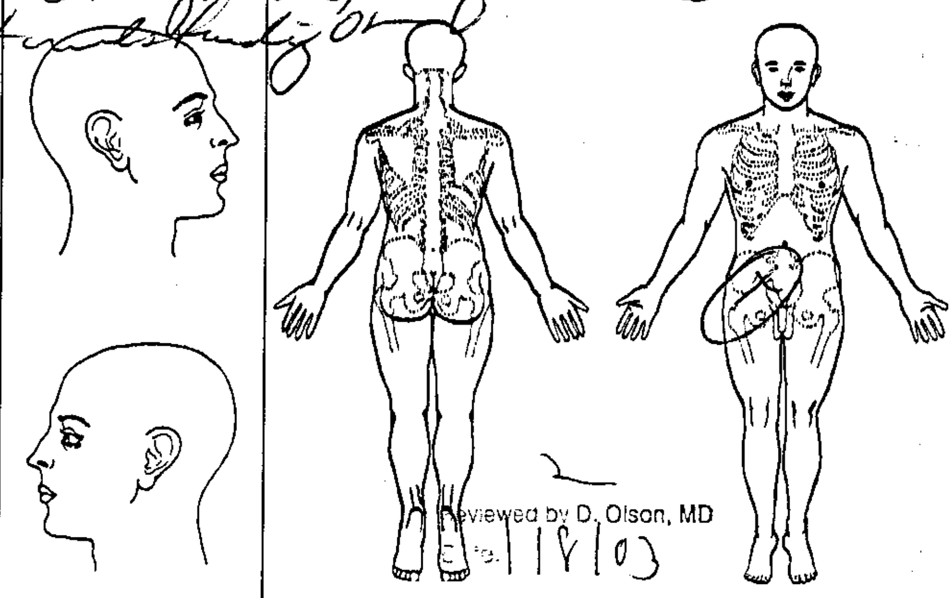
(1) Tylenol 500 TT/8hrs #30 RX1
(2) Ice locally then moist heat, Ben Gay after 24hrs.
(3) Idle x 2 days. No rec 1 month.
(4) Follow up in s/c if needed.
(5) [illegible]

Patient Education
__ Dosage
__ Special Instruction
C. Byler, R.Ph

13. This Injury Required:

☐ a. No Medical Attention
☐ b. Minor First Aid
☐ c. Hospitalization
☐ d. Other (*explain*)

☐ e. Medically Unassigned
☐ f. Civilian First Aid Only
☐ g. Civilian Referred to Community Physician



Signature of Physician or Physician Assistant

J. Gomez, MLP

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

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BP-362(60)

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McClean	SIGGERS, KEVIN	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
UNICOR	CA	9-6-01 18:15
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
REC FOOTBALL FIELD		9-6-01 19:30

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

WHILE RUNNING THE BALL, I STEPPED ON MY BLOCKER'S FOOT AND TURNED MY ANKLE. PAINFUL TO MOVE | BEAR WT.

℞ [signature]
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

(L) lat ankle sl. swollen

X-Rays Taken X *Not Indicated* ____

X-Ray Results

Pt limping. Rates pain 7 1/2-8 on 1-10 pcale

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(L) ankle sprain -pending XR reading

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Ace, Elevate, crutches (teaching), Ice, Tylenol 500 mg (#20) Given
Take 2 every 6-8 hrs for pain. RTC PRN. & RTSC in AM for evaluation by PA 24° Idle given

13. This Injury Required:

- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

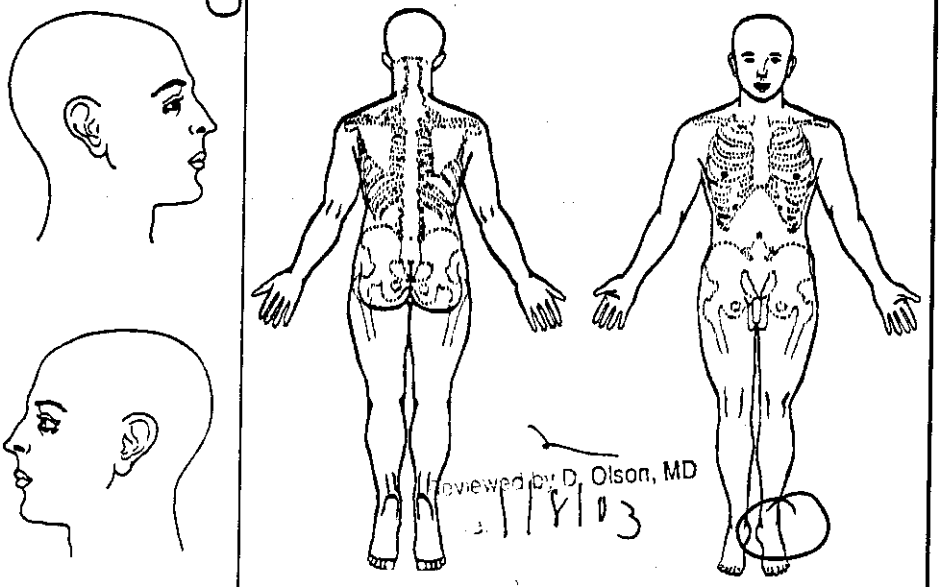
_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

[signature]
Signature of Physician or Physician Assistant

Sandra L. Rimer, RN



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Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

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BP-362(60)
FEBRUARY 1986

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	Siggers, Kevin	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
UNICOR	CA	8/2/01 2045
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
CA 228		~~8/2/01~~ 8/2/01 2145

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

While dancing in my room, I got caught up in my walkman cord, lost my balance and hit my hand on the corner of the locker

Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

Minor interrupted laceration

X-Rays Taken _____ *Not Indicated* ☒
X-Ray Results

dorsum (L) hand ≈ 6cm in length. Scant blood noted.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(L) hand laceration - minor

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Cleansed thoroughly ∈ Nibicleno, dressed ∈ Bacitracin ung and adhesive bandage. Pt ed S/S infection.

13. This Injury Required:

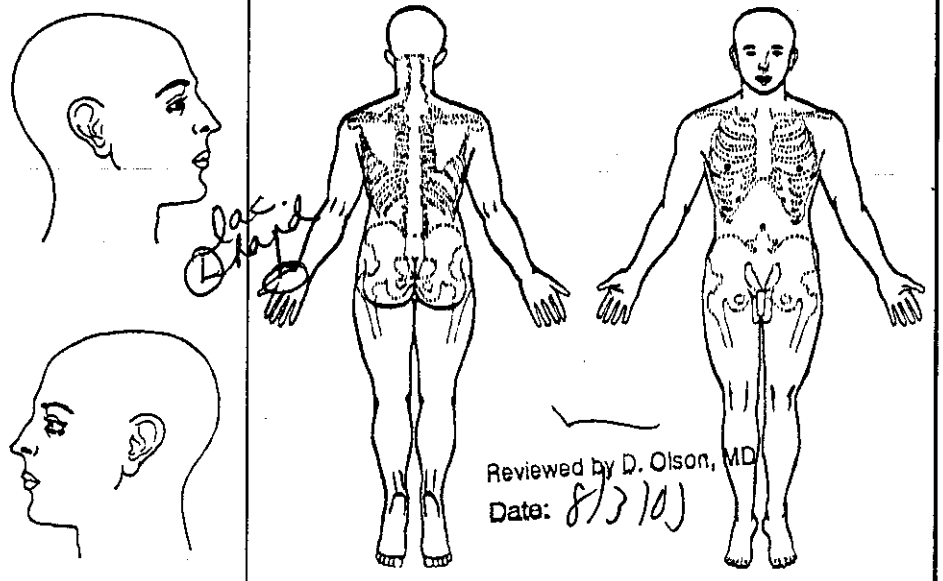
- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Sandra L. Rinner, RN
Signature of Physician or Physician Assistant



Reviewed by D. Olson, MD
Date: 8/3/01

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Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

USP LVN

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BP-362(60)
FEBRUARY 1986

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJ[illegible]SSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FTC · Okcity	Siggers ·	51627- 060.
4. Injured's Duty Assignment	5. Housing Assignment	6. Date and Time of Injury
—	—	9/26/98 1700

7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?*	8. Date and Time Reported for Treatment
3C ·	☐ Yes ☒ No	9/26/98 1900

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

Iemt slipt his leg and fell on floor. and hit his head. he does not loos his cons. he is alert 3xent.

____
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken ____ *Not Indicated* ✓
X-Ray Results

I/M alert 3xent No bleedy. he is Cons. he has Rt. ~~knee fall? Rpen abn.~~ he is fully ambulatory. he has been seen dentistry yesterday. HEENT: Head. Ustrum No

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

ulcerat. Eyes Pupils are equal react on light ✓ facial CVS: HRR. chest clear. Abd soft BS+.

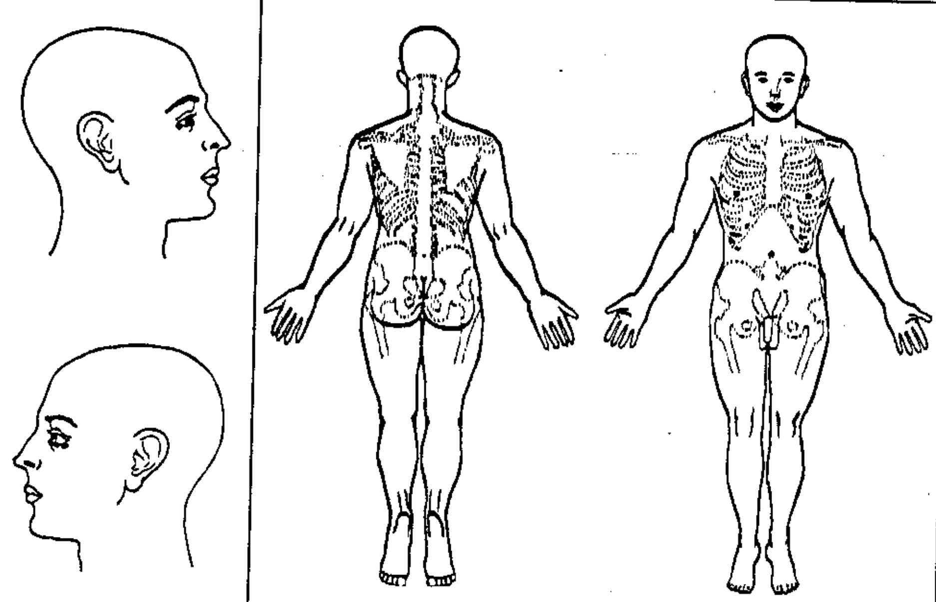
12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Eff no ECC No injury.

13. This Injury Required:

- ☒ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)
- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

A. R. Caraf[illegible]
Signature of Physician or Physician Assistant



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9/28/98 F.T.C. Okc. Ok

ginal – Medical File
ary – Safety
– Work Supervisor (*Work related only*)
denrod – Correctional Supervisor

LVN

BP-362(60)

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FMC Rochester	Liggero Kevin	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
C	1-2	4-29-98 1036
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
1-2		4-29-98 1045

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

We had a disagreement. No other comment

Kevin L. Liggero
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

Face: WNL Eyes PERRLA-EOMI

X-Rays Taken _____ *Not Indicated* X

X-Ray Results

H/E good ROM superficial lacerations (L) 4th finger PIP joint volar surface: L/E good ROM WNL

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

Superficial lacerations: as above

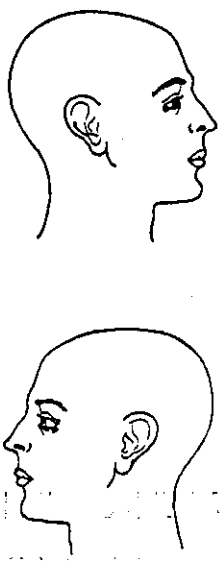
12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

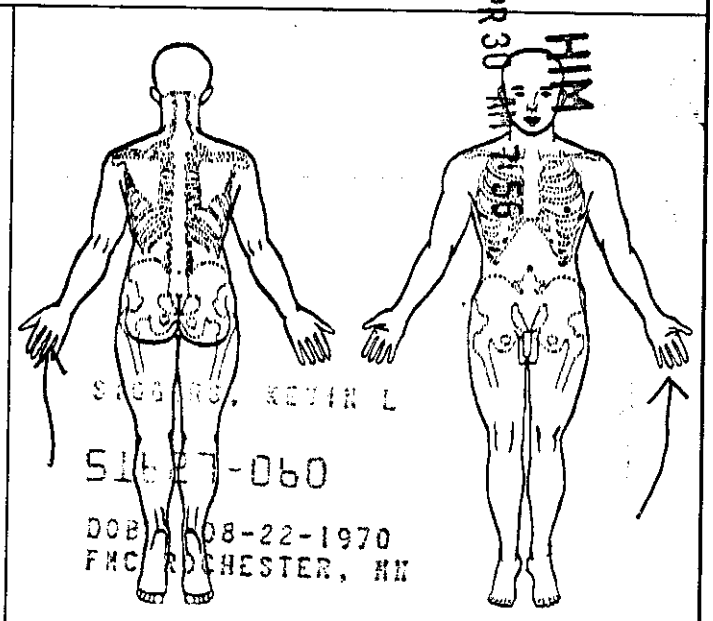
1) Clean 2) monitor for S/SX of infection

13. This Injury Required:

- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)
- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

98 MAY 6 PM 3:30 HIM





J. Sullivan PA-C
Signature of Physician or Physician Assistant

Self Carboned Form – If ballpoint pen is used, **PRESS HARD**

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJUR[illegible]SESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FMC - Rochester	Siggers	51627-060
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
unassigned	1-2 R 204	
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
		4/26/98 1600

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

Pt has a "memory tattoo" on (L) upper arm. I did it myself a few ~~two~~ days ago.

Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken _____ *Not Indicated* X

X-Ray Results

Tattoo on (L) upper arm. 4 inches long.

Skin slightly raised ~~around~~ on writting. No swelling, or drainage, tenderness, redness noted.

No noted scabbing Tattoo of a cross on a tombstone & wording on bottom.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

Tattoo on (L) upper arm Done the last few days. States he did it himself.

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

monitor for infection.

13. This Injury Required:

- ☒ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*)

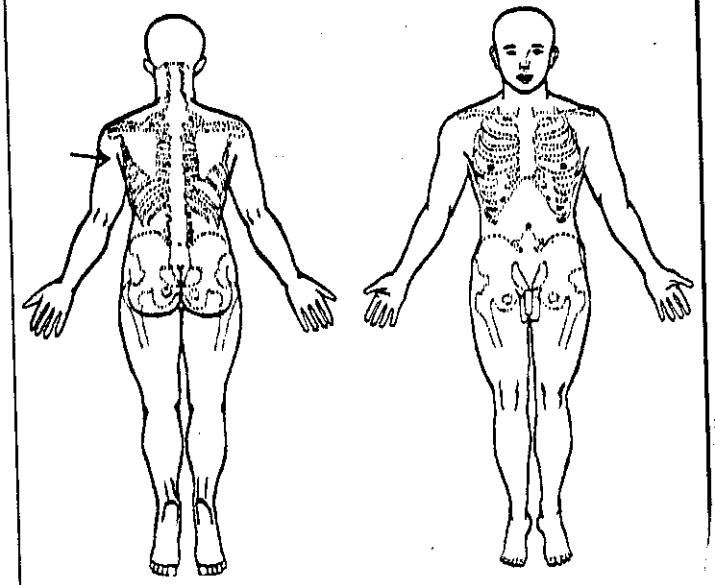
_____

_____

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

Anna Hoff rn

Signature of Physician or Physician Assistant



Self Carboned Form – *If ballpoint pen is used,* **PRESS HARD**

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

Printed on Recycled Paper

BP-362(60)
FEBRUARY 1986

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refu
(Rechazo de Tratamiento M...)

12/15/00
Date (Fecha)

I, Siggers, Kevin 51627-060 , refuse treatment recommended by the Federal
(Name and Registration Number) (Numbre y Número de Registro) (rechaza el tratamiento recomendado por el Personal

Bureau of Prisons Medical staff for the following condition(s):
Médico del Bureau Federal de Prisiones, por las siguientes razones):
DESCRIBE IN LAYMAN'S TERMINOLOGY: (DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE):

1) Depression

The following treatment(s) was/were recommended: (El siguiente tratamiento(s) fue/fueron recomendado(s)):

Trazodone

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

1) Worsening of depression

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehuso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respectar y seguir mis expresos deseos y direcciones.)

Patient's Signature and Date (Firma del Paciente y Fecha)

Dennis Olson PHD 12/15/00
Signature of Witness and Date (Firma del Testigo y Fecha)

Signature of Witness and Date (Firma del Testigo y Fecha)

Original - Inmate's Medical Record
Canary - Hospital File
Pink - To Inmate

Previous editions not usable

BP-358(60)
MAY 1985

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refusal
(Rechazo de Tratamiento Médico)

Date 10-28-98 (Fecha)

I, Siggers, Kevin 51627060 (Name and Registration Number) (Numbre y Número de Registro), refuse treatment recommended by the Federal (rechaza el tratamiento recomendado por el Personal

Bureau of Prisons Medical staff for the following condition(s):
Médico del Bureau Federal de Prisiones, por las siguientes razones):
DESCRIBE IN LAYMAN'S TERMINOLOGY: (DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE):

Depression.

The following treatment(s) was/were recommended: (El siguiente tratamiento(s) fue/fueron recomendado(s)):

Trazodone 50mg QAM.

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

Worsening depression that may lead to suicide and death.

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehuso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respectar y seguir mis expresos deseos y direcciones.)

Patient's Signature and Date 10-29-98 (Firma del Paciente y Fecha)

Signature of Witness and Date 10-28-98 (Firma del Testigo y Fecha)

Signature of Witness and Date 10-28-97 (Firma del Testigo y Fecha)

Original – Inmate's Medical Record
Canary – Hospital File
Pink – To Inmate

USP LVN

Printed on Recycled Paper

BP-358(60)
MAY 1985

What are the risks from influenza vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Almost all people who get influenza vaccine have no serious problems. The viruses in the vaccine are killed, so you cannot get influenza from the vaccine. Mild problems include soreness, redness, swelling where the injection was given, fever, and body aches. If these problems occur, they usually begin soon after the vaccination and last 1-2 days. Life-threatening allergic reactions are very rare. If they do occur, it is within a few minutes to a few hours after the injection.

****

I, X [illegible] Bey 51627060, have read the above statement about the influenzavaccination. I have provided with updated information and have had the opportunity to ask questions about the benefits and risks receiving this vaccination.

FOR WOMEN

Pregnancy can increase the risk for complications from the flu, and pregnant women are more likely to be hospitalized from complications of the flu than non-pregnant women of the same age. In previous worldwide outbreaks of the flu (pandemics of 1918-19 and 1957-58), deaths among pregnant women were associated with the flu. Pregnancy can change the immune system in the mother, as well as affect her cardiovascular system (heart and lung function). These changes may place pregnant women at increased risk for complications from the flu.

Because the flu vaccination is made from inactivated viruses (the viruses are killed), many experts consider flu vaccinations safe during any stage of pregnancy. However, since miscarriages (spontaneous abortion) most often occur in the first trimester of pregnancy, experts have traditionally not given a flu vaccination during the first trimester to avoid a coincidental association with miscarriage.

Women who will be beyond the first 3 months of pregnancy during the flu season should get a flu vaccination. Pregnant women who have medical problems that increase their risk for complications from the flu should get a flu vaccination before the flu season, no matter their stage of pregnancy.

Signature of the Recipient

Signature of Witness

****

DECLINATION FOR VACCINE

I do not want to receive the influenza vaccination at this time.

X [illegible] Bey 51627060 — Signature of the Patient

10/19/05 — Date

B. Douthit EMTP — Signature of Witness

B. Douthit, Paramedic
FCI McKean

(This form may be replicated via WP)

BP-A807.060
SEP 03

INFORMATION ON VACCINATION (CONSENT/DECLINATION) FOR INFLUENZA VACCINE

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

Influenza Vaccine (Flu Shot) for 2005 **(Year)**

NOTE: CONSULT THE CENTERS FOR DISEASE CONTROL FOR ANNUAL UPDATES CONCERNINGVACCINE INFORMATION

Influenza is a serious disease caused by a virus that spreads from infected persons to the nose or throat of others. The "influenza season" in the U.S. is from November through April each year. Influenza can cause fever, sore throat, cough, headache, chills, and muscle aches. People of any age can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes thousands of deaths each year, mostly among the elderly. Influenza vaccine can prevent influenza. Influenza Vaccine Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. Protection develops about 2 weeks after getting the vaccination and may last up to a year.

Persons who should receive the influenza vaccine:

Individuals in any of the following categories:

1. Chronic disorders of the cardiovascular or pulmonary systems,
2. Health individuals 65 years of age or older,
3. Adults with chronic metabolic diseases, including diabetes mellitus, renal dysfunction, anemia, or immunosuppression,
4. Anyone who has extensive contact with high risk individuals,
5. Pregnant women with a medical condition that increases the risk of complications from influenza (should be given after the first trimester),
6. Persons living in dormitories or in other crowded conditions, to prevent outbreaks,
7. Anyone who wants to reduce their chance of catching influenza.

Persons who should not receive the influenza vaccine:

1. Those who have allergic sensitivity to eggs, chicken feathers, chickens or chicken dander,
2. Those who have a hypersensitivity to any components of the vaccine,
3. Have a history of Guillain-Barre Syndrome (GBS),
4. Anyone with a current febrile illness.

When should I get influenza vaccine?

Because influenza activity can start as early as December, the best time to get influenza vaccine is during October and November. But getting the vaccine after November can still provide protection. A new vaccination is needed each year. Influenza vaccine can be given at the same time as other vaccines, including pneumococcal vaccine.

Can I get influenza even if I get the vaccine this year?

Yes. Influenza viruses change often, and they might not always be covered by the vaccine. But vaccinated people who do get influenza often have a milder case than those who did not get the injection. Also, many people call any illness with fever and cold symptoms "the flu." They may expect influenza vaccine to prevent these illnesses, but influenza vaccine is effective only against illness caused by influenza viruses, and not against other illnesses.

Name: X Wm K. Diggs-Bey	
Register No. X 51627060	SSN:
Institution	

I HAVE two
INHALERS THAT NEED
REFILLED. Plus I SPLIT
My THUMB NAIL OPEN AND
NEED SOME BAND AIDS AND CREAM
TO CLEAN IT. WHEN WATER HITS
IT, IT HURTS. THANK You!

Inmate Diggers
#51627060

H. BEAM, MD
FCI MCKEAN
3/10/05

Influenza Vaccine (Flu Shot) for 2004 (Year) NOTE: CONSULT THE CENTERS FOR DISEASE CONTROL FOR ANNUAL UPDATES CONCERNING VACCINE INFORMATION

Influenza is a serious disease caused by a virus that spreads from infected persons to the nose or throat of others. The "influenza season" in the U.S. is from November through April each year. Influenza can cause fever, sore throat, cough, headache, chills, and muscle aches. People of any age can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes thousands of deaths each year, mostly among the elderly. Influenza vaccine can prevent influenza. Influenza Vaccine Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. Protection develops about 2 weeks after getting the vaccination and may last up to a year.

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3. Adults with chronic metabolic diseases, including diabetes mellitus, renal dysfunction, anemia, or immunosuppression,
4. Anyone who has extensive contact with high risk individuals,
5. Pregnant women with a medical condition that increases the risk of complications from influenza (should be given after the first trimester),
6. Persons living in dormitories or in other crowded conditions, to prevent outbreaks,
7. Anyone who wants to reduce their chance of catching influenza.

Persons who should not receive the influenza vaccine:

1. Those who have allergic sensitivity to eggs, chicken feathers, chickens or chicken dander,
2. Those who have a hypersensitivity to any components of the vaccine,
3. Have a history of Guillain-Barre Syndrome (GBS),
4. Anyone with a current febrile illness.

When should I get influenza vaccine?

Because influenza activity can start as early as December, the best time to get influenza vaccine is during October and November. But getting the vaccine after November can still provide protection. A new vaccination is needed each year. Influenza vaccine can be given at the same time as other vaccines, including pneumococcal vaccine.

Can I get influenza even if I get the vaccine this year?

Yes. Influenza viruses change often, and they might not always be covered by the vaccine. But vaccinated people who do get influenza often have a milder case than those who did not get the injection. Also, many people call any illness with fever and cold symptoms "the flu." They may expect influenza vaccine to prevent these illnesses, but influenza vaccine is effective only against illness caused by influenza viruses, and not against other illnesses.

Name: Siggers	
Reg. No.: J7627-060	SSN:
Institution: McKean	

What are the risks from influenza vaccine?

[redacted]

include soreness, redness, swelling where the injection was given, fever, and body aches. If these problems occur, the usually begin soon after the vaccination and last 1-2 days. Life-threatening allergic reactions are very rare. If they do occur, it is within a few minutes to a few hours after the injection.

****

CONSENT FOR VACCINATION

I, _____, have read the above statement about the influenza vaccination. I have been provided with updated information and have had the opportunity to ask questions about the benefits and risks receiving this vaccination.

FOR WOMEN

Pregnancy can increase the risk for complications from the flu, and pregnant women are more likely to be hospitalized from complications of the flu than non-pregnant women of the same age. In previous worldwide outbreaks of the flu (pandemics of 1918-19 and 1957-58), deaths among pregnant women were associated with the flu. Pregnancy can change the immune system in the mother, as well as affect her cardiovascular system (heart and lung function). These changes may place pregnant women at increased risk for complications from the flu.

Because the flu vaccination is made from inactivated viruses (the viruses are killed), many experts consider flu vaccinations safe during any stage of pregnancy. However, since miscarriages (spontaneous abortion) most often occur in the first trimester of pregnancy, experts have traditionally not given a flu vaccination during the first trimester to avoid a coincidental association with miscarriage.

Women who will be beyond the first 3 months of pregnancy during the flu season should get a flu vaccination. Pregnant women who have medical problems that increase their risk for complications from the flu should get a flu vaccination before the flu season, no matter their stage of pregnancy.

Signature of the Recipient Date Signature of Witness

****

DECLINATION FOR VACCINE

I do not want to receive the influenza vaccination at this time.

X [signature] 10/26/04 [signature]

Signature of Patient Date Signature of Witness

(This form may be replicated via WP)

BP-S148.070 APR 94 INMATE REQUEST TO STAFF MEMBER CDFRM
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: DR. BEAM (HOSPITAL) DATE 7-7-04
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

SIR, I'm HAVING stiff & tightness IN MY BACK I HAD A ACCIDENT BEFORE I WAS INCARCERATED AND hurted my "T-12" IN My BACK. I JUMPED UP playing BASKETBALL AND HAS BEEN hurting the LAST few NIGHTS. CAN I PLEASE USE A (BACK BRACE) (BACK SUPPORT) while I'M WORKING.

THANK YOU!!!

(Use other side of page if more space is needed)

E: KEVIN L. SIGGERS SR. NO: 51627060

ASSIGNMENT: AM UNICOR UNIT: CA

you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to lly state your problem may result in no action being taken.

ITION: Do not write in this space)

DATE 7/8/04

WATCH TRO CALLOUT FOR A SICK CALL APPT WITH THE PA

le: Copy - Inmate

Officer

BEAM, MD
MCKEAN

From: Joyce Horikawa
To: Yurkewicz, James
Date: 6/24/2004 1:54:41 PM
Subject: Kevin Siggers, Reg. No. 51627-060

Hi Jim:

I am putting together the litigation report for the Siggers case. I see that he has been a MCK since October 1998 - however, the medical records I have only go back to 2-3-03. Can you have somebody make a copy of the following:

1) 600s from MCK intake (October 21, 1998) through 2-3-2003,
2) problem list (my copy is out of focus and illegible), and
3) can somebody check to see if a CT scan was done (of his chest) in the past year? I have 2 chest x-ray reports (8-5-03, and 1-9-04) - the x-ray rept from 8-5-03 says "Limited Study. Hilar prominence as noted. CT is advised" if a CT scan was done after 8-5-03, I would like a copy.

Thanks!

Joyce

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 4/9/04

TO: Dr. Beam (Hospital)
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

Dr. Beam, I have been Itching very bad Lately. I have tried Vasicline & Lotion but that doesn't work and I don't like scratching infront of People. My perscription for "Diphenhydramine" ran out, and it helped alot with the Itching. Can you please "Re-New" my perscription

THANK you!!

(The Itching is bad on the back of my neck)

(Use other side of page if more space is needed)

NAME: Kevin L. Siggers Sr. NO: 51627060

WORK ASSIGNMENT: A.M Unicors UNIT: C-A

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: Do not write in this space) DATE 4/12/04

We no longer have Benadryl - Try some Hydrocortisone cream from the commissary or come to sick call - send a request to Sign up

Officer

H. BEAM, MD
FCI MCKEAN

Record Copy - File; Copy - Inmate

Date: 1/8/04 Unit: 5Hu

To: Kevin Siggers Reg. #: 51627-060

Your case has been reviewed by our Utilization Review Committee and the decision was:

Approval of your procedure as outlined by Dr Collein

H. BEAM, MD
FCI McKEAN

COP-OUT-
MEDICAL STAFF

TO: MEDICAL RECORDS SUPERVISOR

FROM: INMATE Siggers # 51627060 (SHU)

I would like A copy of All MEDICAL RECORDS & EXAMS giving ME, SINCE I ARRIVED HERE AT F.C.I McKean. Alot of my Legal work was LOSSED OR MISPLACED when I came to (SHU). I will fill out A Form 24 If I NEED to pay for them.

THANK You !!

You have been here since 1998. Please specify, (consults, labs, etc).
12/19/03
FCI McKean

51627060

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
MEDICAL RECORDS	12-30-03
FROM: KEVIN SIGGENS	REGISTER NO.: 51627060
WORK ASSIGNMENT: UNASSIGN	UNIT: CA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I WOULD LIKE COPIES OF ALL EXAMES, PERSCRIBTION, AND RECORDS FROM 6/2000 TO 12/2003. THANK YOU!! I NEED TO SEND THEM TO MY ATTORNEY.

(Do not write below this line)

DISPOSITION:

See attached pages (37)

FCI McKean

Signature Staff Member	Date
J. Lotwyk	12/30/03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 10-28-03

TO: Medical Records
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

I was seen by Dr. Beem today giving a breathing test, which showed my breathing around 200 to 210, where it should be around 400. I would like a copy of today's examination results. Also, any records of treatment on my health in the last 6 months.

Thank you!

(Use other side of page if more space is needed)

NAME: Kevin L. Siggins Sr. NO: 51627060

WORK ASSIGNMENT: RM Unicon UNIT: CA

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: Do not write in this space)

DATE 10/29/03

See attached pages 4

Officer

Record Copy - File; Copy - Inmate

FCI McKean

TO: (Name and Title of Staff Member)	DATE:
[redacted] Medical Records Staff	5-17-03
FROM: Siggens, Kevin	REGISTER NO.: 51627060
WORK ASSIGNMENT: Am. Unicor	UNIT: CA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I am requesting copies of any and all medical records, examination records, sick call examinations records, diagnosis and written results of all examinations dating from September 27th 1999 through and until 5-16-03 (march 16th 2003).

(Do not write below this line)

DISPOSITION:

See Attached
40 pp.

FCI McKean

Signature Staff Member	Date
J. Petrucci	5/20/03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 94 and BP-S148.070 APR 94

BP-S148.055 **INMATE REQUE TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Ms. CALDWELL	3-12-03
FROM: KEVIN L. SIGGERS	REGISTER NO.: ~~51627060~~ 51627060
WORK ASSIGNMENT: A.M UNICORE	UNIT: CA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

Ms. CALDWELL, I NEED A PACKAGE "Authorization SHEET" to get GLASSES IN. I'm ORDERING THEM FROM "PRISM OPTICAL, INC." PO BOX 680030 10992 NW 7TH A N. MIAMI, Florida 33168.

I NEED the "Authorization DATE TO Extend to 6 month for I'm MAKING PAYMENTS ON THEM. I NEED from 3-16-03 to 9-16-03.

I THANK You for Your Help!!

Also I NEED A COPY of My "PERSCRIPTION" My Family couldn't SEND GLASSES This YEAR!!

(Do not write below this line)

DISPOSITION:

Go to speak with Mr. Grant Smith (ISM) and he will explain the process to you.

Signature Staff Member	Date
D. Caldwell, HSPA	3-18-03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Diane Caldwell
Health Services Program Assistant
FCI McKean
P.O. Box 5000
Bradford, PA 16701

Printed on Recycled Paper

BP-S148.055 **INMATE REQU T TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Ms. CALDWELL	3-12-03
FROM:	REGISTER NO.:
KEVIN L. SIGGERS	~~51627~~ 51627060
WORK ASSIGNMENT:	UNIT:
A.M UNICORE	CA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

Ms. CALDWELL, I NEED A PACKAGE "Authorization SHEET" to get glasses IN. I'M ORDERING THEM FROM "PRISM OPTICAL, INC." PO BOX 680030 10992 NW 7TH AVE. N. MIAMI, FLORIDA 33168.

I NEED the "Authorization DATE TO Extend to 6 months, for I'M MAKING PAYMENTS ON them. I NEED from 3-16-03 TO 9-16-03.

I THANK You for Your Help!!

Also I NEED A COPY of My "PERSCRIPTION" My Family couldn't SEND glasses This YEAR!!

(Do not write below this line)

DISPOSITION:

Attached you will find a copy of your prescription. A package authorization has been approved and sent to the mail room. Tinted glasses and hard cases will be rejected.

Signature Staff Member	Date
D. Caldwell, HSPA	3-13-03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Diane Caldwell
Health Services Program Assistant

FCI McKean
P.O. Box 5000
Bradford, PA 16701

Printed on Recycled Paper

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 12-21-02

TO: MRS. CALDWELL (Hospital Glasses Supervisor).
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

MRS. CALDWELL,
My CASE MANAGER MR. WATSON SAID THAT IN ORDER FOR ME TO SEND MY GLASSES OUT AND HAVE MY "NEW PERSCRIPTION" PUT IN THEM, THAT I must GET THE PROPER PAPER WORK FROM YOU!! I WANT THEM MAILED TO MY WIFE AT: MRS. DIANE SIGGERS 1371 E. 115TH ST. APT. 3 CLEVELAND, OHIO 44106. THIS WILL SAVE HER MONEY THAT SHE CAN SPEND ON OUR CHILDREN.

THANK YOU!!!

Neal: Who is this?

(Use other side of page if more space is needed)

NAME: SIGGERS, KEVIN NO: 51627-060

WORK ASSIGNMENT: Mill 1 UNIT: CA

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE January 7, 2003

A package authorization has been prepared and sent to the mail room. Tinted glasses and hard cases will be rejected.

FCI McKean
P.O. Box 5000
Bradford, PA 16701

D. Caldwell, HSA
Officer
Diane Caldwell
Health Services

Record Copy - File; Copy - Inmate

FCI MCKEAN HEALTH SVC.
2003 JAN 13 AM 11:13

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 12-21-02

TO: MRS. CALDWELL (HOSPITAL GLASSES SUPERVISOR)
(Name and Title/of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

MRS. CALDWELL,

MY CASE MANAGER MR. WATSON SAID THAT IN ORDER FOR ME TO SEND MY GLASSES OUT AND HAVE MY "NEW PERSCRIPTION" PUT ON THEM, THAT I MUST GET THE PROPER PAPER WORK FROM YOU. I WANT THEM MAILED TO MY WIFE AT: DIANE SIGGERS 1371 E. 115TH ST. #3 CLEVELAND, OHIO 44106. THIS WILL SAVE HER MONEY THAT CAN BE SPENT ON MY CHILDREN.

THANK YOU!!!

(Use other side of page if more space is needed)

NAME: KEVIN L. SIGGERS SR. NO: 51627060

WORK ASSIGNMENT: A.M. UNICORE UNIT: CA

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE 1-02-2003

To have your glasses sent out for repair, bring the glasses to me in the health services department. They must be ready to mail out (in a package, addressed, with correct postage). **DO NOT SEAL THE PACKAGE - IT MUST BE INSPECTED.**

You will be required to complete some paperwork at that time.

Record Copy - File; Copy - Inmate

FCI McKean
P.O. Box 5000
Bradford, PA 16701

D. Caldwell, HSA
Officer
Diane Caldwell

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) DENTISTS	DATE: 10-9-02
FROM: KEVIN L. SIGGERS	REGISTER NO.: 51627060
WORK ASSIGNMENT: FPC UNICOR	UNIT: CA

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I HAVE BEEN IN MCKEAN SINCE 1998 AND I HAVE SENT MANY COP-OUTS TO GET MY TEETH CLEAN, BEFORE THEY STARTED THIS NEW PROGRAM. GUYS WHO CAME HERE SINCE 2000 HAS SEEN THE DENTIST. I PUT SLIPS IN, IN 1999 WHILE IN SEG. SEPTEMBER AND WAS TOLD I'M ON THE WAITING LIST. THEN I ASKED THE NURSE AT THE WINDOW WHERE I WAS AT ON THE WAITING LIST AND SHE SAID I WASN'T AND TO SUBMIT A NEW COP-OUT AND NOW I'M ABOUT 100 ON THIS LIST. CAN I PLEASE GET MY TEETH CLEAN. THANK YOU !!!!

(Do not write below this line)

DISPOSITION:

We have a cop out in your chart from 12/2001. Please watch the call outs, & your name will be there appox 1 year from the date you were placed on the list.

Signature Staff Member	Date
J Batista	10-9-02

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

U.S. DEPARMENT OF JUSTICE
Federal Bureau of Prisons

INMATE REQUEST TO STAFF MEMBER

DATE: 10-30-01

TO: The Dentist
(Name and title of officer)

Subject: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

Sir, I would like to get my teeth cleaned. I HAVENT SEEN A DENTIST HERE SINCE "1998".

(KEVIN L. SIGGERS)

I'A HAVE MAILED ABOUT FOUR OTHER REQUEST FORMS LIKE THIS, IN THE LAST 18 MONTHS WITH "NO Reply" I WAS told to slide THIS REQUEST UNDER YOUR DOOR. TO MAKE SURE YOU RECEIVE IT.

THANKS !!!!!!

Name: KEVIN L. SIGGERS No.: 51627060

Work assignment: AM UNICOR Unit: C-A

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE: 12-19-01

Your name has been added to the list. Please watch the callouts.

A. Douglass CSA FCI McKean
Officer

Original - File
Copy - Inmate

INMATE REQUEST TO STAFF MEMBER

DATE: 2-7-01

TO: Ms. Caldwell (Health Services) Eye glasses Dept.
(Name and title of officer)

FCI MCKEAN HEALTH SVC.
OFFICE
01 FEB -8 AM 11:30

Subject: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

Ms. Caldwell,

I would like a copy of my new eye glass prescription and a package form so that my mother can send me an a pair. They will be being sent in by; Mrs. Gwen Alexander
2925 Angel Court
Austintown, Ohio 44511

I thank you for your time & help with this matter !!!!

Name: Kevin L. Siggers No.: 51627060

Work assignment: A.m Unicorn Unit: CA

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE:

Attached to this cop out, you will find a copy of your prescription for glasses. A package authorization has been prepared and sent to the mail room.

Original - File
Copy - Inmate

Officer Dana Caldwell, HSPA
Dana Caldwell
Health Services Program Assistant

DATE 3-10-99

TO: "Medical Records"
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

May I please have a copy of my eye glass perscription so that my wife can get the new perscription put in my glasses that I have already and send them to me. Also, After I receive my perscription what paper work will my wife and myself have to fill out for she can send my Glasses in. I thank you for your time concerning this matter.

(Use other side of page if more space is needed)

Mrs. Diane Austin Siggers
1371 E. 115th St. #3
Cleveland, OHIO
44106

NAME: Kevin L. Siggers Sr. No.: 51627-060

Work assignment: Veg. Prep / Food Service Unit: 3A

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE 3/15/99

Attached you will find a copy of your Prescription & the Authorization for Glasses to be sent in.

C. Rymer, R.N.
Officer

Original - File
Canary - Inmate

1-28-98

I Kevin T Diggs Sr. request copies of my psych and medical reports for legal reasons.

Kevin T Diggs Sr.
5/627-060

1-28-98

Copies given to inmate
1- medication sheet
2- phys. reports.

D. Tanner, HIT

D. Tanner, HIT

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE REQUEST TO STAFF MEMBER

FCI MCKEAN HEALTH SVC.
RECEIVED 17 AM 7:16

DATE 12-16-98

TO: Medical Dept. (Eye Doctor)
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

I SENT A REQUEST FORM WHEN I ARRIVED HERE (3) MONTHS AGO AND I HAD A EYE EXAMINE DONE DURING A & O. I NEED GLASSES BAD I HAVE VERY BAD HEADACHE FOR STRAINING MY EYES TO SEE. CAN YOU PLEASE HELP ME,

(Use other side of page if more space is needed)

THANK YOU!!!

NAME: SIGGERS, KEVIN No.: 51627-060

Work assignment: KITCHEN WORKER Unit: 3A

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE 12-17-98

You are on the list.

D. Tanner, HIT
Officer

Original - File
Canary - Inmate

D. Tanner, HIT

CONSENT TO USE OF MISCELLANEOUS ANTIDEPRESSANT MEDICATION

The physician should initial numbers 1 thru 5 after discussing each with the inmate.

I, Sayers, Reg. No. 51627-060 hereby ~~authorize~~
Dr. Saqib or his/her relief (designee), to prescribe ~~trazodone~~ (Desyrel), nefazodone (Serzone), bupropion (Wellbutrin), venlafaxine (Effexor), mirtazapine (Remeron) an antidepressant medication to me and to continue said medication as is recommended for my psychiatric treatment.

1. ✓ This medication is useful because it has been found to be effective in treating depression and its associated symptoms including sadness, fatigue, hopelessness, sleeplessness, loss of appetite, loss of interests, loss of concentration, suicide, or self harm ideation. This medication may also be effective in treating other disorders, such as obsessive-compulsive disorders, panic disorders, or insomnia.

2. ✓ This medication may improve your condition by relieving all or some of the symptoms mentioned above.

3. ✓ Common side effects to this medication include, but are not limited to, dry mouth, blurred vision, constipation, tremor, drowsiness, dizziness, headache, tiredness, insomnia, nausea, fast or irregular heartbeat, decreased appetite, weight loss or weight gain, and increased sweating. These effects are frequently temporary or can be controlled with a change in dosage. Less common complaints include , lack of energy, sleep disturbances, hallucinations, flushing, and decreased sex drive. Seizures are more common when taking Bupropion. Priapism (painful, prolonged erections) are an uncommon side effect of Trazodone. We have reviewed the fact that if you have conditions such as liver or kidney function impairment, or a history of mania, it may be preferable to use other medication.
If any of the above symptoms occur, you should notify Medical Staff at sick call as soon as possible.

4 ✓ Not taking this medication as prescribed by the physician's instruction may lead to a worsening of symptoms. However, some symptoms of depression and related disorders may get better or even go away without taking medication. Also, the risk of suicide may be increased by not taking this medication.

5 ✓ Other treatment options include other medication with similar benefits. Other drugs may cause some of the same side effects you might experience with this medication. Other treatments may not include any medication, but may involve counseling by a psychologist or other medical professional.

Based upon interview, assessment, and medical record review, it is my opinion that this patient understands the proposed treatment, and **is competent** to give consent.
Physician Signature [signature], MD

Based upon interview, assessment, and medical record review, it is my opinion that this patient **is not competent** to give consent. Physician Signature _____

Other issues discussed _____

The undersigned certifies that he/she has read the foregoing, or has had it explained in a language they understand, and hereby consents to treatment and has no additional questions.

[signature]	51627-060	10-21-98
Inmate Signature	Inmate Number	Date
[signature]		10/21/98
Witness Signature		Date
[signature], MD		11/6/98
Attending Psychiatrist or Physician		Date

I understand that I may stop taking this medication at any time by contacting the physician. However, I understand that discontinuing the medication abruptly is generally not advisable.

FCI MCKEAN HEALTH SVC.
2001 OCT 23 AM 7:32

DATE 10-22-98

TO: Eye Doctor
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

I HAD MY EYES ~~EXAM~~ TESTED AT FMC ROCHESTER BUT I WENT BACK TO COURT BEFORE I RECEIVED MY GLASSES. MY EYES HURT FROM STRAINING THEM. CAN I GET TESTED FOR GLASSES HERE

(Use other side of page if more space is needed)

NAME: Kevin D. Driggins Jr No.: 51627-060

Work assignment: N/A Unit: CA

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE 10/23/98

Your name has been added to the waiting list. Please watch the call-outs.

J. Talwar
Officer

Original - File
Canary - Inmate

BP-148(65

U.S. Department of Justice

Federal Bureau of Prisons

Federal Medical Center

FMC Rochester, MN 55903-4600

Date: July 29, 1998

ATTN: Medical Division
Lake County Adult Detention Facility
104 E. Erie Street
Painesville, Ohio 44077

RE: SIGGERS, Kevin
Register No: 51627-060

Please find one (1) copy of the following medical records prepared by the Bureau of Prisons.

- [x] Progress Notes
- [x] Lab Reports
- [x] X-ray Interpretations
- [x] Medication Sheets
- [ ] Psychological /Psychiatric Evaluations
- [ ] Entire Record
- [ ] Other
- [ ] Doctor's Orders
- [ ] Discharge Summaries
- [x] History and Physical
- [x] Consultation Reports

Please note, the enclosed records are provided pursuant to the Freedom of Information Act and Privacy Act of 1974 (Title 5, United States Code, Section 552 and 552a). Further release or other dissemination of these records or the information contained therein is not authorized, except when it is your specific determination that further disclosure will not cause any harm to the patient or other party. See Title 28 CFR 16.43.

If you have any questions, please call me at (507) 287-0674, ext. 472.

Sincerely,

Karen Buelt A.R.T.

Karen Buelt, ART
Medical Records Administrative Specialist
Health Information Management Department

COUNTY OF LAKE

Office of the Sheriff

Daniel A. Dunlap, Sheriff

HIM JUL 27 PM 2:46

FAX TRANSMISSION COVER SHEET

DATE: 7-27-98

NO. OF PAGES: 2 INCLUDING COVER

FAX RECEIVER MINN. PH # 507-287-0874

FACSIMILE TELEPHONE NUMBER: 507-287-9606

TO: KAREN - MED RECORDS

FROM: CAROLYN - LAKE CTY. JAIL PAINESVILLE OHIO

REPLY REQUESTED: X YES ____ NO

FAX OPERATOR: CAROLYN BARBISH

IF TRANSMISSION IS IMPAIRED, PLEASE CONTACT 440-350-5649

PLEASE FAX INFO. TO 440-350-5639

47 Copies mailed out on 7/29/98.

Karen Buelt A.R.T.

KAREN BUELT, ART
HEALTH INFORMATION MANAGEMENT
ROCHESTER